

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23024

State File No. _____

Registration District No. 898Primary Registration District No. 6204Registrar's No. 14

1. PLACE OF DEATH:

- (a) County Weber Co
 (b) City or town Box Dallas Utah
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
 years, months or days)3. (a) PRINT FULL NAME WM CARL JOHN ENGELKING

3. (b) If veteran, _____ 3. (c) Social Security
 name war _____ No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married,
 divorced _____

7. (b) Name of husband or wife Bertrude Engleking 6. (c) Age of husband or wife if
 alive _____ years

7. Birth date of deceased Nov 23 1885
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 7 17 hr. _____ min.

9. Birthplace Bremor Co Iowa
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name John Engleking
 13. Birthplace unknown
 (City, town, or country) (State or foreign country)
 14. Maiden name Winnifred Adams
 15. Birthplace unknown
 (City, town, or country) (State or foreign country)

16. (a) Informant's own signature Bertrude Engleking
 (b) Address Sejmon no R#3

17. (a) Funeral Home (b) Date thereof 7-7-41
 (burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Funeral Home

18. (a) Signature of funeral director Reiley Finner

- (b) Address Sejmon no R#3

19. (a) July 15 1941 (b) John Engleking
 Date received local registrar (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Weber

- (c) City or town Diggins Rural
 (If outside city or town limits, write "RURAL")

- (d) Street No. _____
 (If rural, give location)

- (e) If foreign born, how long in U. S. A. no 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th
 year 1941 hour 5:30 minute a M.

21. I hereby certify that I attended the deceased from _____
 _____, 19____, to _____, 19____;

- that I last saw him alive on _____, 19____;
 and that death occurred on the date and hour stated above.

- Immediate cause of death _____ Duration _____

- Due to Natural causes

- Due to _____

- Other conditions _____
 (Include pregnancy within 3 months of death)

- Major findings: _____
 Of operations _____

- Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____
 (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?
822

- While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature E. G. Bens (M. D. or other) _____

- Address Sejmon no R#3 Date signed 7-14-41

JUL 18 1941

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

H K Kelley

Licensed Embalmer No.

3334

P. O. Address

Seymour Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.